



ARKANSAS COOPERATIVE EDUCATIONAL SERVICES

RE: Testimony on Raised Bill 1105

Dear Education Committee Members:

Thank you for this opportunity to present to the Committee. I would like to express substantial opposition to Raised Bill 1105. After serious consideration of the language and intent of the bill, my opposition, based upon current scientific evidence, the complexity of translating that evidence into training and practice, and considerable experience in our public school systems, leads me to the inevitable conclusion that under the mandates defined in R.B. 1105, students on the autism spectrum are likely to be deprived of carefully designed and managed educational and treatment programs. In the absence of such programs these students are unlikely to achieving levels of independence that allow them to function as participating members within their family and the larger community.

A comprehensive analysis of the peer reviewed research has been undertaken by Betty Fry Williams and Randy Lee Williams in a recently published book entitled, *"Effective Programs for Treating Autism Spectrum Disorder – Applied Behavior Analysis Models"*, 2011, Routledge, New York and London. While the review includes Kanner's (1943) seminal work on autism and Bettelheim's (1967) declaration that parents were to blame for their child's autism, the review clearly focuses on the most current and up to date researcher (ranging from the mid 90's to 2009).

In addition to the research presented below, I would like the education committee to take into consideration the findings of the National Institute of Health (1990). In that report the NIH study group noted that for children with autism spectrum disorders early intervention for behavior problems is "paramount". The NIH also reported that behavior analytical approaches have been the most successful in reducing behavior problems, and simultaneously expressed alarm over the increasing usage of drugs to ameliorate such problems. I think it is critical to recognize that the NIH review of treatment options available for children with autism spectrum was based on behavior intervention programs designed, implemented, and adjusted using outcome data, by persons who were highly trained in behavior analytic theory and had a proven record in the implementation and manipulation of current behavioral technologies. To assume that use of behavioral technology, in isolation from the training required to demonstrate mastery of such technology, is adequate presents a serious error in judgment. Behavior technology can have serious consequences for recipients of such technology when used by persons who have 'minimal' or 'no' training what so ever. I, myself, would not want to be held responsible for the well being and safety of a child or adolescent who engages in self-injurious behavior (e.g., eye gouging, head banging, or hand and arm biting), if I did not feel totally competent in my understanding of both the behavior itself and the treatment of such behavior. While I have provided an example of behavior that is on the extreme end of the continuum, is emotionally charged for staff and parents, and can result in the most serious of outcomes for the student, it is important to understand that such behaviors can be avoided, or quickly ameliorated, if staff are well trained, have demonstrated mastery, and receive appropriate supervision in behavior analytic theory and technology. The education and treatment of children

and adolescents on the autism spectrum is a serious enterprise; but one that has a wealth of empirically validated teaching and treatment approaches. Administrators, teachers, paraprofessionals, and parents can, for example, read a handful of studies on using a DRO to reduce rates of aberrant behavior. Reading research doesn't mean an untrained person will know what to do when the student does not behave as the subjects in the study behaved. It is at this point that one's lack of mastery of the subject matter and technology can result in unwanted outcomes. Outcomes that can result in harm to the student and staff both physically and psychologically.

My written testimony includes the most characteristic concerns that present with autism spectrum disorder. I ask you to review those concerns, read the research, and decide if development, implementation, and supervision of programs for individuals with ASD warrants serious consideration regarding the training, expertise, and supervision of the persons held accountable for such programming.

I appreciate the time you have permitted me to address this most serious consideration that, in the end, you must decide.

From Williams and Williams (2011):

- 1) Problems with social interactions. Some professionals suggest that impairments in social behavior are so fundamental to ASD they should be considered the defining feature (Laushey & Heflin, 2000). Impairments include social orientation, joint attention, and attention to the emotions and feelings expressed by others (Dawson, Toth, Abbott, Osterling, Munson, and Estes, 2004).
- 2) Repetitive behaviors, and limited interests, can often dominate the behavior repertoire of an individual with ASD (Lam & Aman, 2007). Their resistance to change often leads to ritualistic behavior and preoccupation with a particular area of interest severely interfering with opportunities for learning and social interactions (Klin & Volkmar, 1997).
- 3) Cognitive deficits that typically include IQ scores below 70, and half of those identified in the severe and profound range of intellectual deficits. ASD children typically have impairments in executive functioning, the ability to predict future outcomes, and central coherence problems (they can't see the big picture). Conceptual reasoning and comprehension are also commonly impaired (Lainhart, 1999).
- 4) Students with autism also, characteristically, have unusual sensory sensitivities demonstrating greater degrees of hyper and hypo-sensitivities across all sensory modalities when compared to typical students (Talay-Ongan & Wood, 2000). Hyper-sensitivity is most common and can result in a child with autism being extremely upset by noises, visual stimuli, smells, and textures (e.g., certain foods which they will refuse to eat).
- 5) ASD children and adolescents often have deficits in adaptive behaviors (daily living skills) and require highly specialized instruction to acquire and master such skills so that they can become independent (Carothers & Taylor, 2004).

- 6) The mortality risk for individuals with ASD, at least in the severe range, is twice that of the general population and may be related to a number of the deficits noted above, e.g., cognitive, social, and language impairments (Shavelle, Strauss & Pickett, 2001).
- 7) Students with ASD can also present with a number of accompanying disorders including epilepsy which is increasingly recognized as the most common medical disorder accompanying ASD (Canitano, 2007); co-morbid psychiatric disorders and symptoms including moderate to severe depression, bi-polar disorder, suicidal tendencies, schizophrenia, catatonia, anxiety, and OCD (Lainhart, 1999). These problems tend to worsen in adolescents if not successfully addressed early on.
- 8) Sleep disorders are common among individuals with ASD (Lainhart, 1999 and Richdale, 2001). As one might expect sleep disorders can result in worsen developmental functioning, attention impairments, and school related behavior problems.
- 9) Eating disorders, while mentioned above, deserve special attention as they are common in children with ASD. Children with ASD can be extremely fussy in accepting food that does not meet their visual and sensory restrictiveness (Schreck, Williams, and Smith (2004) have reported food acceptance problems centered on issues of color, texture, and type of food).
- 10) Finally, behavioral and emotional problems occur at high rates for children and adolescents with ASD (Tonge & Einfeld, 2003). Self-injurious behavior, mild to severe aggression, elopement (from classrooms, schools, and homes), and property destruction are but a few behavior problems that are commonly seen in students with ASD. These problems often result in serious consequences such as isolation, separation from family, and deprivation of social opportunities.

Respectfully Submitted,

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